FOREWORD

The "V" is the assigned computer character which will appear as a flag for illogical/erroneous combinations of ICD-9-CM codes. This program was developed to assist you in making your hospital's data more accurate for administrative planning, research, legislative analyses, outcome studies, and other uses of OSHPD's patient discharge data.

The coding edits were designed to flag illogical/erroneous ICD-9-CM data reported in:

the principal diagnosis field only, the secondary diagnosis field only, diagnosis field versus diagnosis field, procedure field versus diagnosis field, procedure field versus procedure field, the E-code field only, and E-code field versus diagnosis field.

These coding edits are distinguished as the V edits (not V codes). The "V" edits are numbered from V0001 to V9999. If a V edit flag appears next to an ICD-9-CM code, refer to the <u>ICD-9-CM Coding Edit Manual</u>. The <u>ICD-9-CM Coding Edit Manual</u> lists the V edits in numerical order. Each V coding edit has a description, the coding guideline(s), and the references for the coding guideline(s). Written approvals to cite examples and statements were obtained from:

- Coding Clinic for ICD-9-CM
- ICD-9-CM Coding Handbook With Answers by AHA
- Coding Notes in the Journal of AHIMA
- CHIA Coding Modules I and II
- Journal of CHIA.

Instructions: After correcting the Coding Edit Detail Report, return it to OSHPD.

If you choose to follow your hospital's coding policy that is different from the *Coding Clinic for ICD-9-CM* guidelines, please inform Tella M. Williams, RHIA, at OSHPD, 818 K Street, #100, Sacramento, CA 95814, E-mail address: twilliam@oshpd.state.ca.us or FAX to 916-327-1262.

<u>IMPORTANT NOTE:</u> Effective with the January 1, 2000 through June 30, 2000 discharge data report, corrections to the Coding Edit Report will be required. This report will be used as a measure of errors for ICD-9-CM codes. The current error tolerance level for the diagnoses, procedure and external cause of injury data elements is .1%.

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